



CLAIMS CLUES

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NON-EMERGENCY TRANSPORTATION UPDATE

Effective 6/1/2006, the following changes will be made for any Fee For Service Indian Health Service and/or ALTCS Fee For Service non-emergency **ground** transport:

- Roundtrip transports of **100 miles or less WILL NOT** require Prior Authorization. See note below.
- Roundtrip transports **OVER** 100 miles for **FFS IHS** will continue to require authorization in the manner outlined in the following "Prior Authorization Request Form".
- Roundtrip transports **OVER** 100 miles for **ALTCS FFS** will continue to require authorization from the ALTCS Tribal case manager as before.

NOTE – Transportation Providers may bill without obtaining prior authorization as long as the total mileage billed on any one CMS 1500 claim form does not exceed 100 miles.

AHCCCS will conduct retrospective audits of transportation providers to verify that the mileage, diagnosis, and medical necessity are correct and justifiable. The transportation provider will need to provide AHCCCS with a trip report, and IHS referral (not required for ALTCS FFS members), and justification of transport upon request by AHCCCS anytime after the date of service.

All transportation prior authorization requests **for ALTCS FFS members** must be approved by the member's ALTCS Tribal Case manager.

For FFS IHS members only:

Please be advised that effective June 1, 2006, we are asking that all transportation prior authorization requests be faxed to the AHCCCS Prior Authorization Department at 602-417-4687. Please use the following Prior Authorization request form to request authorization.

If you have any special circumstances that need to be addressed immediately, you may call the transportation line. We request that all other requests, mileage changes, procedure code changes, and modifications be faxed to the above number.

If you have an IHS referral, you **DO NOT** need to complete the Prior Authorization Form. You only need to write your Provider ID# and the mileage on the referral and fax it to the above number. Please make sure that the Prior Authorization and Referral Forms are filled out completely and that eligibility has been verified.

Also, please remember:

- Emergency Ground and Air Ambulance transports **DO NOT** require authorization. Use the emergency codes, mark the emergency box, and submit your claim form.
- Requests for Prior Authorization and/or referrals need to be submitted **PRIOR** to the date of transport. This policy has always been in effect and will be enforced. Please allow 24 to 48 hours for authorization numbers to be issued (for FFS IHS members). You may also check status of authorizations online at the AHCCCS website, www.azahcccs.gov.
- Submitting a claim if the authorization is pended will result in a denied claim.
- Until further notice, please submit **one date of service per claim submission**.

The AHCCCS Provider Manuals have been updated with this information and are available on the AHCCCS website for your reference.

**See following page for Fee For Service IHS Transportation
Prior Authorization Request Form**



AHCCCS Fee For Service
Transportation Prior Authorization
(602) 417-4400 Option 1
(602) 417-4687 Fax

A.H.C.C.C.S. F.F.S. I.H.S. Transportation
Prior Authorization Request Form

Today's Date _____

AHCCCS ID# _____

Provider ID # _____

Provider Name _____

Member Name _____

Date of Service _____

Diagnosis _____

Mileage _____ Rural _____ Urban _____

Amb. Van _____ Wheelchair Van _____ Stretcher Van _____

BLS Ambulance _____ ALS Ambulance _____ Emergency _____

*****Emergency Transports do not require authorization*****

Trip From _____

Trip To _____

****All transportation requests will be pended for I.H.S. Referral until referral is received by AHCCCS. Please allow 24 to 48 hours for authorization number to be issued. PA request must be received on or before the date of the transportation, with the exception of weekends and holidays.**

****Please do not submit a claim form for payment until an authorization is approved and matches your claim form. This will result in a denial and delay in payment.**

Contact information: _____

Comments: _____

*****Fax Request Form to (602) 417-4687**

JCAHO ACCREDITATION REQUIRED FOR FACILITIES THAT PROVIDE PSYCHIATRIC SERVICES TO MINORS

In order for a health care organization to participate in and receive payment from Medicare and Medicaid, it must first be certified as complying with the Conditions of Participation, or standards, set forth in Federal Regulations. This certification is based on a survey usually conducted by a state agency on behalf of the Centers for Medicare and Medicaid Services (CMS). In Arizona, CMS contracts with the Arizona Department of Health Services to conduct surveys of hospitals to certify them as complying with the Conditions of Participation.

Since the enactment of the Social Security Amendments of 1965, hospitals with JCAHO accreditation have been deemed as meeting the Federal Conditions of Participation. Accreditation through JCAHO or any other national accrediting body is voluntary and seeking deemed status through accreditation is an option, not a requirement.

There is one instance where AHCCCS specifically requires JCAHO accreditation for an acute care hospital.

- The AHCCCS Behavioral Health Services Guide requires psychiatric hospitals and inpatient psychiatric programs in a hospital to be accredited through JCAHO if providing treatment to clients under age 21. Federal Regulation 42 CFR 441.151 requires JCAHO accreditation for psychiatric hospitals or inpatient psychiatric programs in hospitals providing inpatient psychiatric services for individuals under the age of 21 and in certain circumstances until age 22. (If these services are provided in non hospital psychiatric facilities, the facility must be accredited by JCAHO, by the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards recognized by the State).

INCONTINENCE BRIEFS ARE COVERED FOR EPSDT RECIPIENTS

As of March 3, 2006, AHCCCS covers incontinence briefs for EPSDT recipients who have a documented disability, in order to prevent skin breakdown, and to enable participation in social, community, therapeutic and educational activities. Minimum documentation requirements for coverage include:

- a. Current documentation of a disability that causes incontinence
- b. A prescription from a Primary Care or attending physician ordering incontinence briefs

The following codes are available for billing purposes:

T4521 (Adult sized disposable incontinence product, brief/diaper, small, each)

T4522 (Adult sized disposable incontinence product, brief/diaper, medium, each)

T4523 (Adult sized disposable incontinence product, brief/diaper, large, each)

T4524 (Adult sized disposable incontinence product, brief/diaper, extra large each)

T4529 (Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each)

T4530 (Pediatric sized disposable incontinence product, brief/diaper, large size, each)

T4533 (Youth sized disposable incontinence product, brief/diaper, each)

T4539 (Incontinence product, diaper/brief, reusable, any size, each)

A4520 (Incontinence garment, any type, (e.g., brief, diaper), each)

Contractors and AHCCCS may impose reasonable Prior Authorization and Network requirements.

Affected Chapters in the AHCCCS Medical Policy Manual include 300, 400, 800 and 1200. This manual is available on the AHCCCS website for your reference.

OUTPATIENT OBSERVATION SERVICES
BILLING REQUIREMENTS CHANGE
EFFECTIVE 7/1/2006

Observation services, *without labor*, billed on the UB claim form must be billed with a **0762** Revenue Code (Treatment/Observation Room – Observation Room), Observation services, *with labor*, billed on a UB claim form must be billed with **0721** Revenue Code (Labor Room Delivery – Labor) ***and*** the appropriate observation HCPCS procedure code as outlined below:

FOR DATES OF SERVICE 7/1/2005 THRU 6/30/2006

99218, 99219 OR 99220 (note that 99217 is not appropriate for hospital billing).

FOR DATES OF SERVICE 7/1/2006 FORWARD

G0378

Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

On-line Fee For Service Provider Manual will be updated with this change.

SELECTING ELECTRONIC PAYMENTS IS EASY AND CONVENIENT

AHCCCS has made it easy for providers to begin receiving electronic fee-for-service reimbursement. The electronic payment option processes payments using the Automated Clearing House (ACH) rather than issuing checks to providers. The ACH payment method enables providers to receive reimbursement more quickly. The Arizona Clearing House Association (ACHA) processes electronic payments directly to the provider's bank account through Bank of America, which functions as the state servicing bank.

BofA will make the electronic payment available to a provider's account one business day after the date AHCCCS transmits the ACH payments file to BofA. The ACH process offers several benefits to providers, including:

- Immediate availability of funds
- Fully traceable payments
- Elimination of mail and deposit delays
- Elimination of lost, stolen, or misplaced checks

To begin receiving ACH payments, a provider must complete Sections 2 and 3 of the ACH Vendor Authorization form.

This form is available on the AHCCCS website at www.ahcccs.state.az.us. Click on the links for Plans and Providers. On the Quick Links for Health Plans and Providers page, click on Forms, and then scroll down to the ACH Vendor Authorization Form. The provider's financial institution must complete Section 4 of the form.

Submit the form to:

AHCCCS Finance Dept
Mail Drop 5400
P O Box 25399
Phoenix, AZ 85002

AHCCCS Finance staff will complete Section 1 of the form to initiate the electronic payment process. AHCCCS will process its normal weekly fee-for-service payment cycle and transmit the ACH payment data to BofA, which will transmit the information to ACHA. On the settlement date of the electronic payment, the provider's financial institution will credit the provider's individual account. Providers who have questions should call (602) 417-4052 or (602) 417-4543.

NATIONAL PROVIDER IDENTIFIER (NPI)

Effective January 23, 2004, the final rule regarding the National Provider Identifier (NPI) was published. CMS started assigning NPI numbers to providers last May. AHCCCS will require the NPI number to be used as the healthcare provider identifier in all claim submissions starting in May 2007.

An electronic mailbox has been established for providers to forward a copy of their NPI notification via email. **This email address can only accept copies of the statement mailed to the provider from the NPI enumerator.** The AHCCCS provider ID number also needs to be included in the email for identification purposes. The email address is NationalProviderID@azahcccs.gov.

Other options for providers to submit a copy of their NPI number notification include mailing or faxing a copy of the enumerator statement. The provider's name and AHCCCS provider ID number needs to be written on the copy. The information can be mailed or faxed to:

**AHCCCS
Provider Registration Unit
P O Box 25520
Phoenix, AZ 85002**

Fax: (602) 256-1474

NPI numbers will also be accepted via written notification. Notification must include the AHCCCS provider's name, AHCCCS provider ID number, NPI number and signature of the provider or authorized signer.

The agency is targeting January 1, 2007 as the optional claims and encounter submission date. Effective May 23, 2007, ALL claims and encounters must be submitted with the NPI when applicable.

Providers can obtain additional information about NPI at www.cms.hhs.gov/hipaa/hipaa2. This site contains Frequently Asked Questions and other information related to the NPI and other HIPAA standards.

VACCINES FOR CHILDREN (VFC) PROGRAM

As a reminder, providers who bill for administration of vaccines under the federal Vaccines for Children (VFC) program must bill the appropriate CPT code for the immunization with “SL” (State supplied vaccine) modifier.

Under the VFC program, providers are paid a capped fee for administration of vaccines to recipients 18 and younger. Because the vaccine is made available to providers free of charge, they must not bill for the vaccine itself. Providers must not use the immunization administration CPT codes of 90471, 90472, 90473 and 90474 when billing under the VFC program. An **updated listing** of vaccines covered under the VFC program is included on the following page for your reference. This information will also be updated in the Fee for Service Provider Manual and the IHS/Tribal Provider Manual available via the AHCCCS website.

It is important to note that CPT code 90715's description per AMA is listed “....for use in individuals 7 years and older”, however the FDA's description states, “for children 10 years and older.” AHCCCS is following the FDA description for age.

The following CPT codes were **excluded effective 6/1/2006**:

- 90646 – Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only
- 90698 – Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza b and poliovirus vaccine, inactivated (DTap-Hib-IPV), (intramuscular use only)

The following codes were **excluded effective 7/1/2006**:

- 90634 – Hepatitis A vaccine, pediatric/adolescent dosage – 3 dose Schedule
- 90645 – Hemophilus influenza b vaccine (Hib), HbOC conjugate – 4 dose Schedule
- 90659 – Pneumococcal conjugate vaccine, polyvalent, for children under 5 years of age
- 90701 – Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)
- 90718 – Tetanus and diphtheria toxoids (Td)
- 90720 – Diphtheria, tetanus toxoids and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
- 90721 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
- 90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3 dose schedule
- 90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4 dose schedule

VACCINES COVERED UNDER THE VACCINES FOR CHILDREN (VFC) PROGRAM

90633	Hepatitis A vaccine, pediatric/adolescent dosage-2dose schedule
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule)
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule)
90655	Influenza virus vaccine, split virus, preservative, for children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative, for use in individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage (covered under VFC only for high-risk children)
90658	Influenza virus vaccine, split virus, 3 years and above (covered under VFC only for high-risk children)
90660	Influenza virus vaccine, live, for intranasal use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live for oral use
90700	Diphtheria, tetanus toxoids, and acellular pertussis (DTaP)
90702	Diphtheria and tetanus toxoids (DT) absorbed
90707	Measles, mumps and rubella virus vaccine (MMR)
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live for subcutaneous use
90713	Poliovirus vaccine, inactivated (IPV)
90714	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, 7 years or older, IM
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), 10 years or older, IM
90716	Varicella virus vaccine, live
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90734	Meningococcal conjugate vaccine, serogroups A, C, and Y and W-135 (tetravalent), for IM use
90732	Pneumococcal polysaccharide, 23 valent
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)
90743	Hepatitis B vaccine, adolescent (2 dose schedule)
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)
90748	Hepatitis B and Hemophilus influenza b (HepB-Hib)

It is important to note that CPT code 90715's description per AMA is listed "...for use in individuals 7 years and older", however the FDA's description states, "for children 10 years and older." AHCCCS is following the FDA description for age.

Updated 6/30/2006

CLAIMS CORRECTION REQUEST FORM HAS BEEN UPDATED FOR PROVIDER USE

AHCCCS has updated the ***CLAIM CORRECTION REQUEST FORM*** for Provider use.

The following page is the updated version all Providers are required to begin using immediately. The completed Claim Correction Request Form must include

- Provider's name
- Provider's AHCCCS ID #
- Provider representative's name
- The recipient's name
- Recipient's AHCCCS ID #
- Dates of Service
- Billed amount
- Claim Reference # (CRN) of the claim you wish to correct
- Fields you wish to change/correct

Providers are encouraged to include comments to clarify changes being requested. **AHCCCS will now also require the signature of the Provider Representative and the date.**

The completed Claim Correction Request Form may be faxed to the AHCCCS Claims Research Unit at 602-253-5472.

Please note that Claims Customer Service Unit will **require** Providers requesting changes to a previously submitted claim to complete this form and fax, as stated above.

On-line versions of the AHCCCS Fee For Service Provider Manual and the IHS/Tribal Provider Billing Manual will be updated to reflect this revised form.



CLAIM CORRECTION REQUEST FORM

Provider Name: _____ **AHCCCS Provider ID #:** _____ **Provider Representative:** _____

Please complete one request form for each Provider ID.

Recipient's name:		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

This is to certify the information submitted and changes listed/requested on this Claim Correction Request Form are true, accurate and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.		Date
Signature of Provider Representative (Required):		

OMB APPROVES THE REVISED 1500 HEALTH INSURANCE CLAIM FORM

The NUCC is pleased to announce the approval of the revised version of the 1500 Health Insurance Claim Form (version 08/05) that accommodates the reporting of the National Provider Identifier (NPI). The Office of Management and Budget (OMB) has approved the 1500 Claim Form under OMB Number 0938-0999 with an initial expiration date of June 30, 2007. The Centers for Medicare and Medicaid Services (CMS) will begin the renewal process for the form in January 2007.

The NUCC is currently working to coordinate the printing and distribution logistics and will communicate them via press release once they are finalized and available.

At this time, there has been no change to the NUCC's recommended timeline for transitioning to the revised form. The timeline remains:

October 1, 2006: Health Plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised (08/05) 1500 Claim Form.

October 1, 2006 = February 1, 2007: Providers can use either the current (12/90) version or the revised version of the 1500 Claim Form.

February 1, 2007: The current version of the 1500 Claim Form is discontinued; only the revised form is to be used. All rebilling of claims should use the revised form from this date forward, even though earlier submissions may have been on the current form.

The following is the proposed Medicare implementation timeline: the new Form CMS=1500 (08/05) will be effective for optional use starting January 2, 2007 through March 30, 2007, but will be required starting April 2, 2007.

Providers will need to check with their payer and/or clearinghouses to determine when they will begin to accept the revised forms.